Department of Children's Services

FOSTER OR ADOPTIVE PARENT/APPLICANT MEDICAL REPORT

A. MEDICAL HISTORY:

Name: _____ Birthdate: _____

Street Address: _____

City: _____TN Zip Code: _____

The report of a current physical examination and full family medical history are required as an essential part of the appraisal of a home and family for the placement of a child.

B. FAMILY HISTORY:

Relation (1)	Age (2)	Health Status (3)	Age at Death (4)	Cause of Death (5)	Has any Relative Listed in Column 1 had the following:	Yes	No
Father					Tuberculosis		
Mother					Diabetes		
Spouse					Malignancy		
Brothers					Epilepsy		
Sisters					Kidney Disease		
					Heart Disease		
Children					Hypertension		
					Alcohol/Drug Addiction		
					Mental Illness		
					Mental Retardation		
					Physical Handicap		

C. INDIVIDUAL HISTORY: (*Check applicable boxes if you have or have ever had the following:)*

	Yes	No		Yes	No
Heart Disease			Kidney Disease		
Malignancy			Multiple Sclerosis		
Veneral Disease			Muscular Distrophy		
Hypertension			Epilepsy/Convulsions		
Ulcers			Thyroid Disorder		
Diabetes			Asthma Allergies		
Tuberculosis			Alcohol/Drug Addiction		
Anemia			Mental Illness		
Arthritis					

List and give dates of any operation, injuries or illnesses requiring hospital care: _____

_____

_____

D. AUTHORIZATION

I, _____, hereby authorize any physician named below to give to the Tennessee Department of Children's Services any information needed in their investigation.

Name of Physician	Address
1. _____	_____
2. _____	_____
3. _____	_____

Department of Children's Services

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(This page to be completed by the physician)

A. Please mail completed report directly to: _____ _____
(*Name)* *(Title)*

_____
(Office Street Address)

_____
(City) *(Zip Code)*

B. **MEDICAL EXAMINATION:**

Height_____ Weight_____ Blood Pressure_____ Pulse_____

How long have you known this patient? _____ Does this examination reveal any evidence of past or present disease of:

	Yes	No	Do you consider patient to be:	Yes	No
Skin or lymph glands			Emotionally stable		
Eyes, ears, nose, throat			Well adjusted		
Heart and lungs			Capable of meeting needs of growing children		
Stomach and abdomen			Do you consider marriage stable		
Genito-urinary system					
Central nervous system					
Venereal disease					

Give additional information if indicated. Use additional sheet if needed.

_____

_____

_____

C. **LABORATORY FINDINGS:**

Tuberculin skin test: _____

Results of other tests as applicable: _____

_____

_____

_____

Specify any physical, mental, or emotional problems which would affect this person's ability to care for a child. If the patient is identified as other adult living in home, indicate conditions detrimental to a child's placement in home: _____

_____

_____

(Omit this item for "other adult" living in home)
On the basis of this examination and my knowledge of this patient, I recommend _____ I do not recommend _____ him/her as a foster or adoptive parent for children. Comments: _____

_____

Date: _____ Signed: _____ M.D.

Address _____